

## Foster Family Home - Corrective Action Report

Provider ID: 1-110004

Home Name: Maricel Manuel, CNA

Review ID: 1-110004-1

94-736 Kaaka street

Reviewer: Carrie Wakal

Waipahu

HI

96797

Begin Date: 3/1/2018

End Date: 3/04/2018

Foster Family Home Required Certificate [17-1454-6]

6.(d)(1) Comply with all applicable requirements in this chapter; and

Comment:

6.d.1-Home visit made for a new 2 client CCFFH certification survey. Corrective Action Report was issued during the visit with a Corrective Action Plan due to CTA by 3/15/18.

Foster Family Home Personnel and Staffing [17-1454-41]

41.(b)(7) Have a current tuberculosis clearance that meets department of health guidelines; and

Comment:

41(b)(7)- CG #5 has a completed TB screening form but there is no proof of positive TST (tuberculin skin test) and/or chest x-ray.

Carrie Wakal  
Compliance Manager

Ammanuel  
Primary Care Giver

3-01-2018  
Date

03-01-18  
Date

Community Care Foster Family Home (CCFFH)  
Written Plan of Correction for Deficiencies  
Listed in Corrective Action Report  
Chapter 17-1454

CCFFH Name: maricel manuel

CCFFH Address: 94-736 kaaka st waipahu hi 96797

Rule Number	Corrective Action Taken	Date Corrected	Prevention Strategy
41.b.7	CG#5 provided the copy of his chest x-ray, kept it in the home record.	03/02/18	In the future I will make sure that I have a current copy of my SCG's TB clearance. I will notify my SCG two months in advance to complete new TB form screening before expiration date.

Primary Caregiver's Signature: Manuel

Print Name: MARICEL MANUEL

Date of Signature: 03-02-18